# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

**PART I: GENERAL INFORMATION**

| | |
|---|---|
| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (x) Yes ( ) No |
| Requestor's Name and Address<br>Maximum Therapeutic Initiative, LLC<br>PO Box 5427<br>San Antonio 78201-0427 | MDR Tracking No.: M4-04-5213-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address BOX #: 29<br>San Antonio ISD c/o Tristar Risk Mgmt.<br>PO Box 461089<br>San Antonio TX 78246-1089 | Date of Injury:<br>Employer's Name: San Antonio ISD<br>Insurance Carrier's No.: 026272622594100021 |

**PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)**

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 1/14/03 | 1/16/03 | 97112 | $105.00 | $105.00 |
| 1/14/03 | 1/16/03 | 97250 | $129.00 | $129.00 |
| 1/14/03 | 1/16/03 | 97150 | $81.00 | $81.00 |
| 1/14/03 | 1/16/03 | 97110 x4 | $420.00 | $0.00 |
| 1/16/03 | 1/16/03 | 97750-FC (2 hr) | $200.00 | $200.00 |

**PART III: REQUESTOR'S POSITION SUMMARY**

1/14/04: "TO TWCC MDR, Enclosed you will find…MDR –60…HCFA's…Reconsiderations…EOB's…"

**PART IV: RESPONDENT'S POSITION SUMMARY**

1/23/04: "Bills were originally received…audited by Medical Audit Consultants and denied as provider did not submit adequate documentation to support continued therapy beyond the initial treatment and nationally recognized treatment guideline."

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

CPT codes *97112, *97250, *97150, *97110 for DOS 1/14/03, 1/15/03 and 1/16/03 were denied "N- Payment is denied because provider did not submit adequate doc to support continued therapy beyond the initial treatment and nationally recognized treatment guideline."

*Code 97112, 97250, 97150: According to MFG/MGR (I)(A)(10) and CPT code descriptor, after review of the documentation received, these services were substantiated and reimbursement is recommended. Amount due: 97112 ($35.00) x 3 days =$105.00 97250 ($43.00) x 3 days=$129.00 97150 ( $27.00)x 3 days= $81.00

*Code 97110, according to MFG/MGR (I)(A)(9-10), documentation submitted for review did not support supervision by the doctor or HCP in either a group or one-to-one setting. Review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicates overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general

obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the

matters in light of all the Commission requirements for proper documentation. The MDR declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Therefore, additional reimbursement not recommended.

CPT code 97750-FC on DOS 1/16/03 was denied "N – Payment is denied because provider did not submit doc of an FCE or time in & out." Documentation supports time in and time out, and sufficient information reported to receive reimbursement according to MFG/MGR (I)(E)(2-b). Therefore, reimbursement is recommended as the billed amount of $200.00.

**PART VI: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $515.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

**Ordered by:**

| Authorized Signature | Carol Lawrence | 3/31/05 |
|---|---|---|
| | Typed Name | Date of Order |

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____